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ABSTRACT

A descriptive model was developed of the dimensions of possible counseling interventions. The three dimensions are the target of intervention, purpose of interventions, and type or method of intervention. The target of the intervention refers to the possibility of interviewing with the individual, his primary or associational groups, or the institutional or societal groups that influence his behavior. The second dimension refers to whether the purpose of the intervention is remedial, preventative or developmental. The method of intervention may be directly by a professional or indirectly through the use of paraprofessionals, media or other means. These dimensions are explained further and examples are provided illustrating each classification. A definition of outreach which is based on the model is presented. Outreach programs are defined as any program which extends beyond the individual/remedial/direct intervention cell of the model. (Author)

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Dimensions of Counseling Intervention

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DIMENSIONS OF COUNSELING INTERVENTION[1]

Weston H. Morrill, E. R. Oetting, and James C. Hurst

Over the years many authors have addressed themselves to a wide variety of approaches or orientations within psychological counseling.[2] Intervention concepts such as prevention,[3] remediation,[4] outreach[5], normal development,[6] mental health,[7] subprofessionals,[8] and consultation,[9] in counseling have been discussed and described. To date, however, there has been no effort to systematically tie these concepts together in a meaningful fashion to describe the dimensions of counseling intervention. The purpose of this paper is to present a preliminary descriptive model of the dimensions of counseling intervention. Counseling intervention denotes the broad range of counselor behaviors which are designed to produce changes in clients, groups, or institutions. This is an attempt to provide a model which will allow the description and categorization of a broad range of possible counseling interventions.

Figure 1 presents a model of the three dimensions to be discussed. The model presents the dimensions orthogonally even though in actual practice they are not purely independent. This model will allow the identification and

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The authors express appreciation to Dorothea M. Bellinger for her able assistance on the project.

[2]Where there are multiple references they will be placed at the end of the paper for ease of reading. The references will be listed by footnote number.

Insert Figure 1 about here

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classification of a variety of counseling programs or counseling approaches as a means of categorizing and describing the potential activities of counseling centers.

The three dimensions described are:

A. The target of the intervention, which referred to interventions aimed at (1) the individual, (2) his primary group(s), (3) his associational groups, or (4) the institutional or societal groups that influence his behavior.

B. The purpose of the intervention, referring to whether the purpose of the interventions is of (1) a remedial nature, (2) a preventative nature, or (3) a developmental nature and not involving a problem orientation.

C. The method of intervention, whether direct or indirect. That is whether the counselor is (1) directly involved in initiating and implementing the intervention, or (2) if he is indirectly involved through consultation, training of others, or use of media.

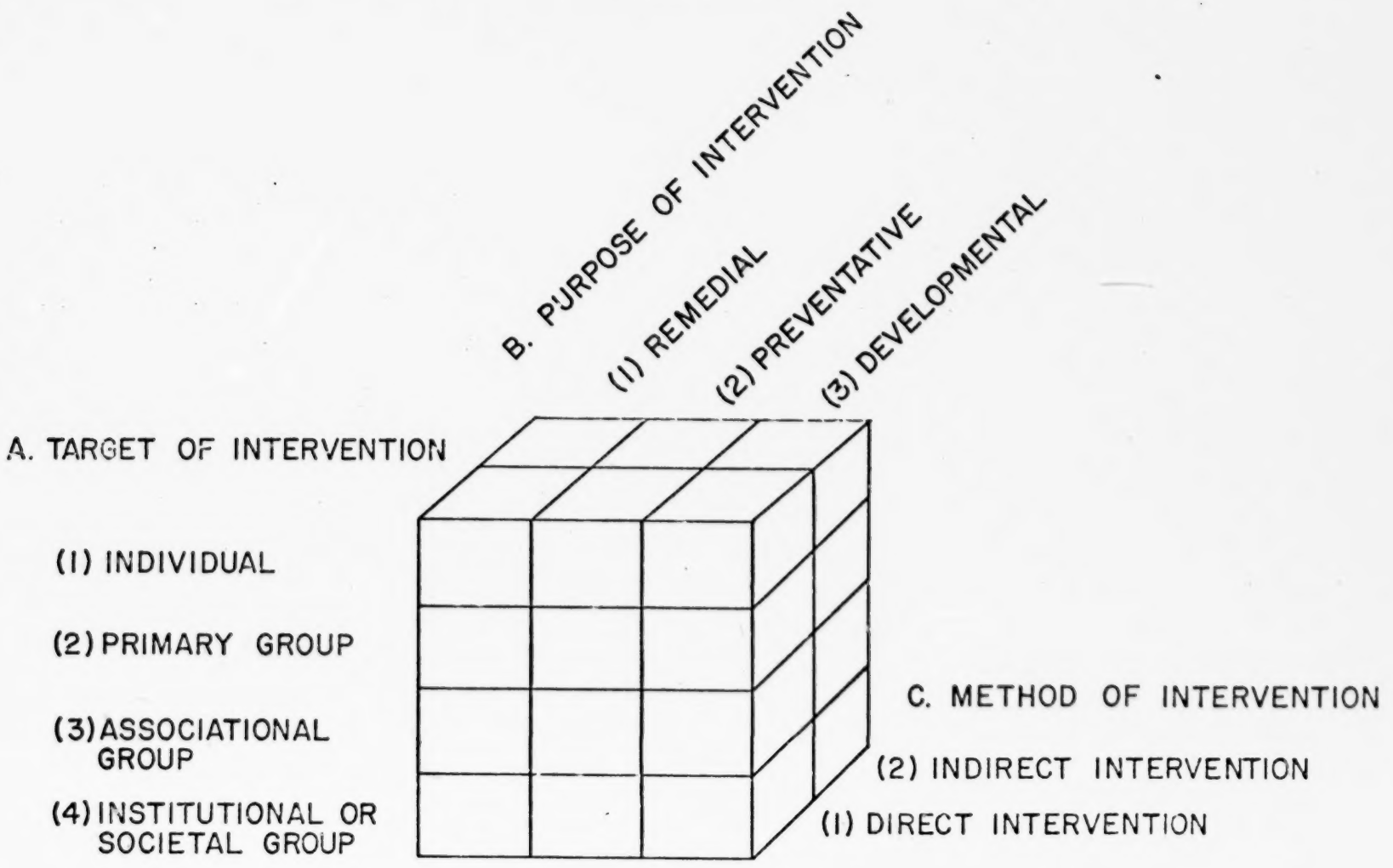
In essence, the dimensions deal with who or what the intervention is aimed at, why the intervention is attempted, and who will do the intervention. In the sections that follow we will expand on these dimensions and then discuss our specific definition of outreach.

A. The Target of the Intervention

The question of the target of counseling intervention has not been asked very often by the profession. The answer to the question has generally been assumed to be the "individual." That is, the objective of counseling, whether directive or non-directive is to produce positive changes in the individual client. The move to group counseling does not reflect an effort to change the "group" but to influence "individuals" by the group[10]. This dimension raises the possibility that interventions in the groups and institutions that influence individuals may be as effective and perhaps in some

Figure 1

Dimensions of Counseling



cases more effective methods of influencing the quality of life of the individual.[11]

The purpose of this dimension, then, is to indicate a range of possible alternative foci for intervention. It begins with the individual being the target of the intervention and then describes other key groups that can be the focus of the intervention. The problem of classifying groups and introducing order among them is not an easy task. As Bierstedt (1970) indicated:

> This, for various reasons, is one of the most difficult problems in contemporary sociology. Many sociologists have attempted a solution, but a standardized classification has not yet been achieved. Furthermore, the more logical such classifications are, the less useful they tend to be; and the more useful, the less logical [p. 300].

The authors do not presume to accomplish what sociology has not accomplished, but present a classification which we find meaningful. Other classifications are possible and could be used with equal validity to describe this dimension. The counselor can choose to intervene at any one of the following four levels:

1. Individual. The target of the intervention is the individual on either a one-to-one basis or a small group basis. Clients are worked with one at a time or a few at a time in a small group setting. The attempt is to influence the individual through altering his knowledge, attitudes, perceptions, responses, etc.

2. Primary or strong identification group. The target of the intervention can be on the primary or strong identification groups that affect the individual. The "primary group" is the basic unit of social organization. This concept, introduced by C. H. Cooley in 1909, refers to those groups which are most influential for the individual. They are described as intimate,

personal associations on a face-to-face continuing basis. The primary group is based on the degree of intimacy rather than proximity. Association and identification with these groups strongly influences the individual's self-concept. The behavior of individuals in the group and their presence or absence from the group influence the other individuals in the group as well as the group itself. Examples of primary groups include families, couples, friends, roommates, and in some cases a suite in a dorm or even a dorm floor.

Interventions at this level would include attempts to alter communications, interactions, perceptions, structure, and relationships in the individual's primary groups.[12]

3. Associational groups. The target of the intervention can be the associational groups to which individuals belong. Bierstedt (1970) uses the term associational groups to describe the more organized groups to which individuals belong. These are groups that are based on choice and somewhat chance associations. Group members have consciousness of similar interests or needs and band or join together in some organizational way to pursue those interests. The distinction between this and societal or institutional groups is that members of associational groups meet together with other members of the group. Examples of associational groups are class sections, a club, the students on a floor in the dormitory, all of the students in a dormitory, student government group, etc.

Interventions at this level would include attempts to alter communications patterns, interactions, organization, goals, methods of achieving goals, etc.[13]

4. Institutional or societal groups. The aim of the intervention can be on institutional or societal groups. These groups differ from associational groups in that they do not necessarily involve meeting together of the members of the group. Members are aware of their membership as parts of an institution,

such as a college, university or school, a community, or a society. These groups also involve a distribution of power.

Interventions at this level would include attempts to alter goals, communications, system linkages, power distribution, information flow, sanctions, etc.[14]

The essence of the first dimension, then, is whether the specific counseling program or effort is designed to deal directly with the individual or whether it will attempt to deal with one or more of those groups that influence individuals.

B. The Purpose of the Intervention

The second dimension, purpose, denotes what the intervention is attempting to accomplish. The purpose of the intervention may be the remediation of an existing problem, the prevention of a potential problem, or the promotion of developmental skills leading to positive and creative growth.

The intent of this dimension is to note some important differences in the orientation of counseling programs. This dimension indicates the possibility of both a reactive and proactive role for the counselor. In the past, some counseling centers have seen their role as totally reactive. That is, they were available to see a client after he (the client) had recognized that he had a problem and came to the counselor seeking help. The counselor then reacted with remedial efforts. This dimension recognizes the role of prevention as well as that of promoting positive development. The purpose of the intervention can be any one of the following:

1. Remediation. Interventions at the remedial level are aimed at providing some skill which has been needed in the past and which was not there. The focus is to bring the individual or the group towards adequate present functioning.[15] In this situation there is generally some pain involved for individuals and this pain has made it obvious to the individual or group

that some action is needed of a remedial nature. In this situation, there is and has been a discrepancy between the individual skill and the environmental demands that exist. This is demonstrated, for example, by the individual who finds himself in a literature class that demands voluminous reading but who has a reading ability level of about 98 words per minute and a low comprehension level. Unless the skill is quickly acquired, the individual will fail the course and perhaps eventually be forced to leave school altogether.

2. Prevention. This aspect of the purpose dimension attempts to identify those skills which are needed by individuals in the present or which may be needed in the future and providing a means for their acquisition. The intent is to anticipate future problems and move to prevent them by providing individuals with needed skills or by creating changes in the environment so as to prevent the development of problems.[16] This dimension encompasses both the primary and secondary prevention as described in the public health model.[17] An example would be the recognition that transition from high school to college is a traumatic experience for many students. Programs designed to lessen the casualties of this period could include such things as group programs to create primary group support for individual students, pre-college counseling to prepare the student for the transition, attempts to modify institutional rules and procedures which contribute to the problem such as registration, faculty advising, etc. The objective is to provide the skills needed by the individual to adequately meet his environmental demands as well as attempt to modify unnecessary and debilitating environmental demands.

3. Development. This purpose of intervention recognizes the role of the counselor in providing programs for all students and individuals and not just those identified as having or potentially having problems. This dimension

describes those programs which are designed to enhance the functioning and developmental potential of individuals.[18] Here programs are proactive promoting the development of potential. This dimension is related to prevention but has a primary focus of promoting positive growth and not preventing future problems.

An example of a developmental program is a couples' workshop designed to enhance the growth and enjoyment of a marriage relationship. It is not meant to alleviate serious relationship problems or substitute for marriage counseling. The goal is to provide a means for adequately functioning partners to enhance and gain greater joy and meaning from their marriage relationship (Hinkle & Moore, 1971). Other examples would include leadership development programs (Dildine, Keltz, Hubbell & Smith, 1969) and career development programs aimed at providing individuals with skills needed to influence his own development (Morrill & Forrest, 1970).

C. The Method of Intervention

There are a variety of ways that a program can be operated. The professional can attempt to deal directly with the target population, or he can work with other individuals to improve their ability to deal with clients. The professional is involved directly with the client in the former example and indirectly in the latter example. The intent of this dimension is to indicate both direct and indirect roles for the professional. The limited number of professionals available in most settings has made it essential that some means of increasing their range of influence be developed. This dimension is related to the target dimension in that efforts to work with institutions are also means of extending the range of influence of the professional. This dimension (type or method of intervention) however, is designed to deal with

who does the actual intervention, whether the professional is directly or indirectly involved in the presentation of programs or services.

1. Direct intervention. Most of the usual counseling programs have been by direct intervention. Vocational counseling and therapy have traditionally involved the professional in face-to-face contact with the client on both an individual and small group basis.[19]

Direct intervention is necessary in some instances. There are situations where professional skills and experience can be critical. The person involved in critical stress frequently needs the highest level of help (Ichikawa, 1964; Peavy, 1968). There are problems that require experienced judgment or skills that only fully qualified professionals can bring to bear. There are other situations where the status of the professional is important, where it provides reassurance or the charisma that is necessary for a particular program.

The disadvantages of direct programs include cost, both monetary and scarce professional time, the ability to deal with only small numbers of clients and the limitations in reaching some groups of clients or to provide some kinds of programs (Lipsman, 1969).

2. Indirect intervention. Following are some descriptions of possible forms of indirect intervention. Each is an attempt to either reach a larger number of people with less professional staff time or to reach clients who could not otherwise be effectively approached. Indirect programs could include indirect attempts to reach clients through other people such as a training program for dormitory aids or assistants, consultation with individuals in other helping roles on campus, consultation with school administration, consultation with faculty and faculty groups, and many other types of training and consultation approaches.[20] The community mental health movement has strongly emphasized the role of consultation during the past decade. The

basic concept has been that the professional can have greater impact if he worked with people who work with the client. With limited resources and almost unlimited mental health problems, this approach has been widely used.[9]

Another indirect method is the selection and training of paraprofessionals to work in a variety of settings.[8] In this instance, the professional is involved in conceptualizing a program and in selecting and training the paraprofessional. The direct service whether to individuals or groups is provided (indirectly by the professional) through paraprofessionals. Another indirect program involves the use of various communications media.[21] These could include the campus newspaper, radio programs, Magoon's (1964) juke box, and many other possible media approaches. These are efforts and attempts to reach and influence individuals through other than direct intervention by a professional.

What is Outreach?

In an earlier paper by Morrill and Oetting (1970), outreach was defined as those activities which involve a counselor in interactions with relevant populations in locations other than his counseling office. Our current thinking about outreach is to class all programs and interventions which are not individual, remedial, and direct intervention as outreach. Thus, on the model (Figure 2) the shaded cell represents individual, remedial and direct intervention, while the remainder of the cells are defined for our purposes as outreach. The cornerstone of most counseling center programs and counselor training programs is represented by the individual-remedial-direct intervention cell of the dimension. Experience and research indicates that this is the activity that most counseling centers spend the greatest amount of time on. Thus, we are including as outreach any programs that move from

this cell in any direction on any one or combination of the dimensions.[5]

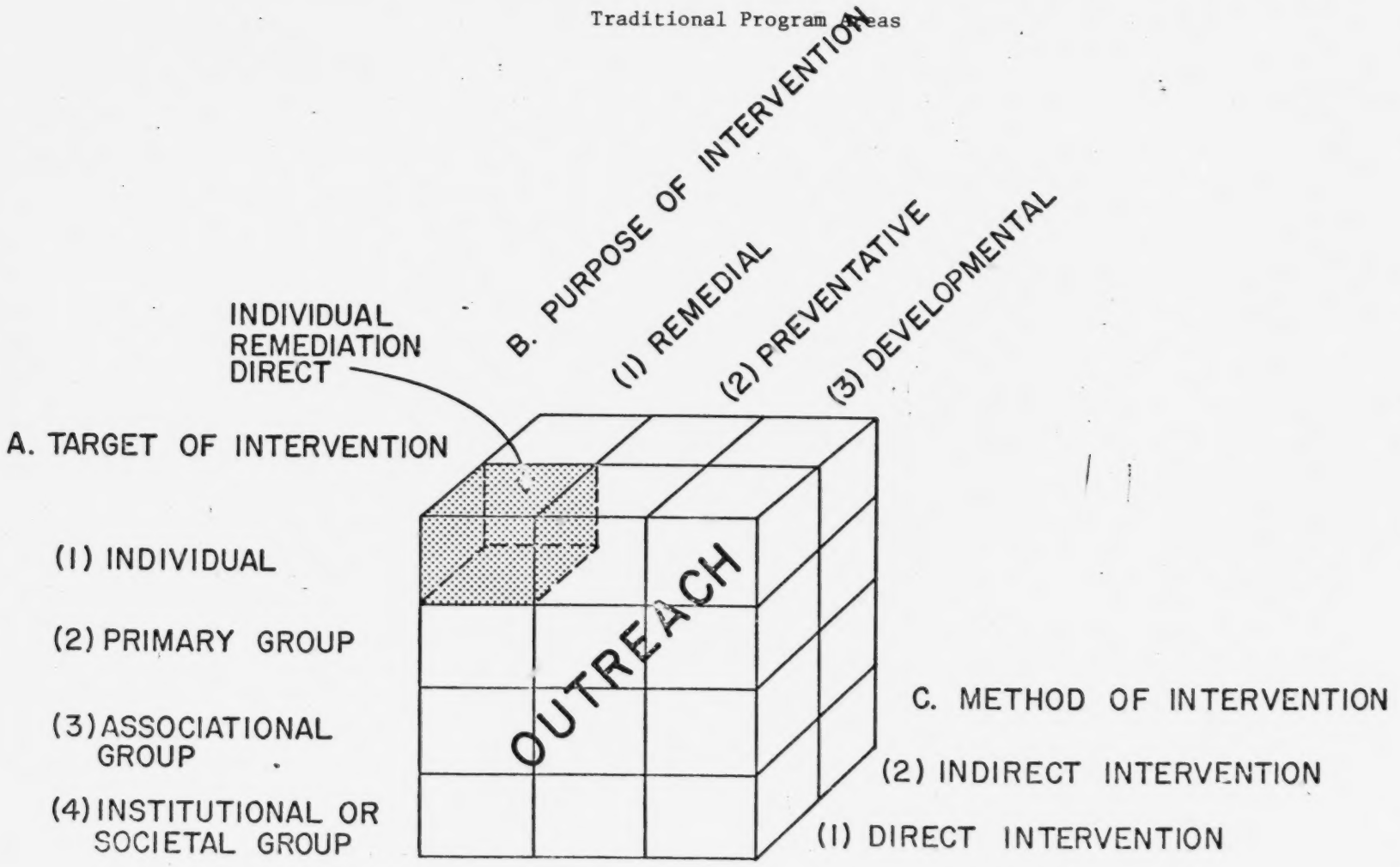
Insert Figure 2 about here

The definition of outreach, then, moves away from some of our earlier thinking of outreach as only those activities involving the counselor somewhere on campus other than in his office. The location of his work is important, but not nearly as important as the nature of the activities and the goal or intent of the activities of the counselor. If we move the counselor out of the office and into some other location on campus and have him continue doing individual remedial direct interventions, then we aren't classifying this as outreach. It is simply decentralization. If, however, a counselor initiates a preventative program, focused on a primary group and implemented indirectly, this is an outreach program regardless of the physical location of the program.

Just a final word or two about the model as we have developed it. As indicated earlier, we recognize that the dimensions are not necessarily independent but that there is a great deal of overlap between them. We have found, however, that this dimension is useful for us in describing and categorizing programs that have been or are being offered in various counseling centers.

Figure 2

Counseling Dimensions Contrasting Outreach and Traditional Program Areas



Footnotes

[2]Brown, B., 1969; Caplan, 1961; Darling, 1957; Freedman, 1968; Hume, 1968; Knutson, 1963; Pratt & Tooley, 1966.

[3]Bloom, 1965, 1967, 1971a; Bower, 1963, 1967; Caplan, 1964; Cutler, Spieth & Wilkinson, 1962; Kubie, 1959; Lemkau, 1966; Parad, 1964; Ruenberg, 1953; Sanford, 1965; Waldfogel & Gardner, 1961.

[4]Blumberg, 1968; Osterweil, 1966; Paulsen, 1967; Peavy, 1968; Phillips, L., 1968; Shoben, 1962; Thorne, 1965.

[5]Anderson, 1970; Forrest, Moore & Hinkle, 1969; Levy, 1969; Moore, Hinkle, & Forrest, 1971; Morrill & Hoyt, 1971; Morrill & Hurst, 1971; Morrill & Oetting, 1970; Warnath, 1969; Winter, 1970.

[6]Cady, 1969; Danskin, 1965; Farnsworth, 1966a, 1966b; Foulds & Guinan, 1969; Gallagher & Demos, 1970; Knutson, 1963; Lowe, 1968; Morrill, Ivey & Oetting, 1968; Nidorf, 1970; Oetting, 1967; Shaffer & Martinson, 1966; Sutich, 1967; Zaccaria, 1969.

[7]Brickman, 1964; Klein, 1965, 1969; Levenson & Brown, 1968; Lipsman, 1969; Martin & Horner, 1967; Shore & Mannino, 1969; Whittington, 1969.

[8]Brown, W., 1965; Cantoni & Cantoni, 1965, 1967; Carkhuff, 1968; Cowen, 1968; Crane & Anderson, 1971; Felzer, Bullock, DeWitt & Wolf, 1968; Gendlin, 1968; Hallowitz, 1968; Halpern, 1969; Hart, Kroll, Berkowitz & Woolcock, 1968; Harvey, 1964; Holand & Voss, 1968; Ledyard & Hadley, 1965; Magoon & Golann, 1966; Phillips, C., 1968; Preuss, 1967; Riessman & Hallowitz, 1967; Sinnett & Niedenthal, 1968; Wolff, 1969; Zunker & Brown, 1966.

[9]Altrocchi, Spielberger & Eisdorfer, 1965; Aseas, 1970; Berlin, 1964; Bindman, 1959, 1969; Brockbank, 1968; Caplan, 1963; Gibb, 1959; Glidewell, 1959; Goldin, 1970; Harris, 1967; Loeb, 1968; Maley & Levine, 1967; Newman, 1965; Robbins & Spencer, 1968; Seashore & Van Egmond, 1959.

[10]Abel, 1967; Balsar, Brown, Brown, Laski & Phillips, 1957; Craig, 1967; Dickenson & Truax, 1966; Foulds & Guinan, 1970; Gold, 1968; Peavy, 1968; Privette & Merrill, 1966; Stephenson & Scarpitti, 1968.

[11]Bloom, 1965, 1971a; Bower, 1967; Grinnell, 1969; Klein, 1965; Kubie, 1959; Lipsman, 1969; Martin & Horner, 1967; Nidorf, 1970; Seashore & Van Egmond, 1959.

[12]Forrest, Moore, & Hinkle, 1969; Freeman, 1965; Linden, Goodwain, & Resnik, 1968; Meadows & Taplin, 1970; Wight, 1968.

[13]Felzer, Bullock, DeWitt, & Wolf, 1968; Moore, Hinkle, & Forrest, 1971; Muldoon, 1968; Preuss, 1967; Seashore & Van Egmond, 1959; Stark, 1964.

[14]Caplan, 1964; Crookston & Blaesser, 1962; Cutler, Spieth & Wilkinson, 1962; Grinnell, 1969; Hallowitz, 1968; Knutson, 1963; Lindemann, 1965; Niehoff, 1967; Sanford, 1965; Swisher & Horman, 1970; Waggoner & Waggoner, 1968.

[15]See remedial references, footnote 4; Abel, 1967; Bednar & Weinberg, 1970; Craig, 1967; Dickenson & Truax, 1966; Jarvis & Stutzman, 1969; Kuehn, 1970; Linden, Goodwain & Resnik, 1968; Roth, Mauksch & Peiser, 1967; Sinnett & Niedenthal, 1968; Stephenson & Scarpitti, 1968.

[16]See prevention references, footnote 3; Cowen, 1968; Paulsen, 1967; Swisher & Horman, 1970.

[17]Brown, B., 1969; Cady, 1969; Ruenberg, 1953.

[18]See developmental references, footnote 6; Foulds & Guinan, 1970; Gold, 1968; Knutson, 1963; Ledyard & Hadley, 1965; Moore, Hinkle, & Forrest, 1971; Preuss, 1967; Privette & Merrill, 1966; Stark, 1964; Vich & Rhyne, 1967.

[19]Bednar & Weinberg, 1970; Burck, 1969; Foulds, Wright & Guinan, 1970; Freeman, 1965; Giffin & Bradley, 1969; Goodrich, 1953; Linden, Goodwain & Resnik, 1968; Meadows & Taplin, 1970; Privette & Merrill, 1966; Vich & Rhyne, 1967.

[20]See subprofessional & consultation references, footnotes 8 & 9; Bloom, 1971b; Caplan, 1961; Facos, 1963; Grinnell, 1969; Higgins, Ivey & Uhlemann, 1970; Jaffe & Reed, 1969; Kansas State University, 1971; Loughary, Frieson & Hurst, 1966; Martinson & Zerface, 1970; Mitchell, 1967; Tucker, Megenity & Vigil, 1970.

[21]Higgins, Ivey & Uhlemann, 1970; Magoon, 1964; Public attitudes to mental health education, 1968.

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